AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Fyzical Therapy & Balance Centers
9136 S Sheridan Rd Suite B
Tulsa, OK 74133
918-488-9991 Phone
918-488-9989 Fax

Being competent, eighteen (18) years of age or older and duly authorized; do willfully and voluntarily authorize all medical records and medical information

To be released from:

Fyzical Therapy & Balance Centers

To be released to:

_____

_____All dictated reports

_____All diagnostic reports

_____All radiology reports

_____All therapy records

_____Other_____

I FURTHER UNDERSTAND AND ACKNOWLEDGE THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY OR MAY NOT INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND HUMAN IMMUNODEFICIENCY VIRUS(HIV), ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR "AIDS"

_____ _____

Full Name of Patient (please print) Date of Birth

_____ _____

Authorized Signature Today's Date